European Commission

State of Health in the EU

Latvia

Country Health Profile 2021

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European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profile series

The State of Health in the EU's Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

Demographic and socioeconomic context in Latvia, 2020

Demographic factors	Latvia	EU
Population size (mid-year estimates)	1 907 675	447 319 916
Share of population over age 65 (%)	20.5	20.6
Fertility rate[1] (2019)	1.6	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	21 398	29 801
Relative poverty rate[3] (%, 2019)	22.9	16.5
Unemployment rate (%)	8.1	7.1

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat database.

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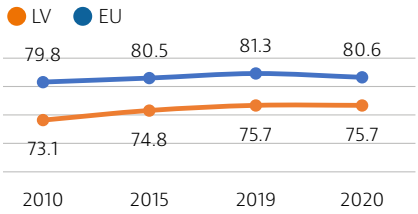
1 Highlights

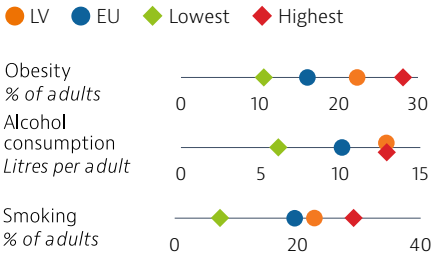
Despite progress before the COVID-19 pandemic, life expectancy in Latvia remains low compared to other EU countries due to the relatively high prevalence of behavioural risk factors, as well as low public spending on health and care accessibility issues. While Latvia was largely spared from the first wave of COVID-19, towards the end of 2020 the infection rate spiked, bringing to light issues around equipment and staff shortages. To support the health care system during the pandemic, the government made available additional funding for equipment, staff bonuses and structural improvements.



Life expectancy at birth, years

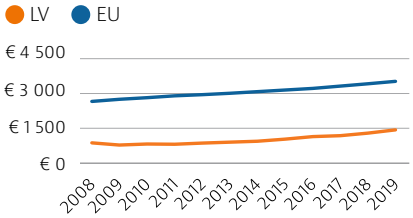
Health Status

Despite significant gains over the past two decades, the life expectancy of the Latvian population remains among the lowest in the EU. Moreover, the COVID-19 pandemic disrupted the steady growth trend in 2020. The gender gap in life expectancy is more than nine years – the second highest in the EU – and the life expectancy of Latvians varies considerably by educational level.



Risk factors

Latvia faces a considerable health burden from behavioural risk factors: the country has the highest level of alcohol consumption in the EU, and one in four men binge drink monthly. The proportions of obese adults and adults who smoke daily are well above the EU average. The Ministry of Health has developed a number of plans and policies to reduce these risk factors over the coming years.



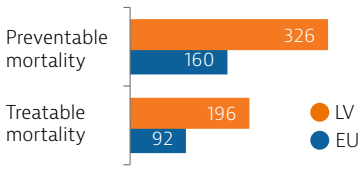
Per capita spending (EUR PPP)

Health system

Latvia has a national health system with strong government stewardship, but which remains severely underfunded. Even though health expenditure per capita has increased by 75 % since 2010, the level remains the fourth lowest in the EU. Only 61 % of health expenditure is publicly funded, and the share of out-of-pocket spending is the second highest in the EU.

Effectiveness

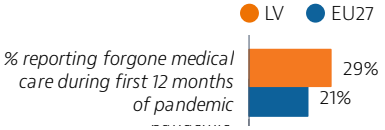
Latvia's mortality rates from both preventable and treatable causes are the second highest in the EU. Cancer screening rates are low, despite efforts to increase uptake; this is reflected in high mortality rates for screening-amenable cancers. The Ministry of Health has a clear strategic focus on prevention and health promotion, but resources are limited.



Age-standardised mortality rate per 100 000 population, 2018

Accessibility

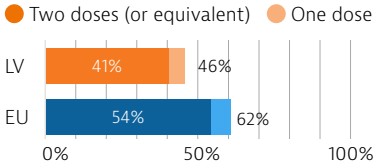
Unmet needs in Latvia were among the highest in the EU, both before and during the COVID-19 pandemic. This is driven by high out-of-pocket expenditure and a benefits package that is comparatively narrow and limited by a quota system. As a result, 15 % of households experienced catastrophic spending on health. The uneven geographical distribution of health professionals creates further barriers to access.



% reporting forgone medical care during first 12 months of pandemic

Resilience

While the impact of the first wave of COVID-19 in Latvia was moderate, by the end of 2020, the infection rate and mortality rate increased greatly, and equipment, personnel and bed shortages occurred. The government provided funding support to the health care system during the pandemic. By the end of August 2021, 46 % of the population received two doses or equivalent, which was below the EU average.



Share of total population vaccinated against COVID-19 up to the end of August 2021

2 Health in Latvia

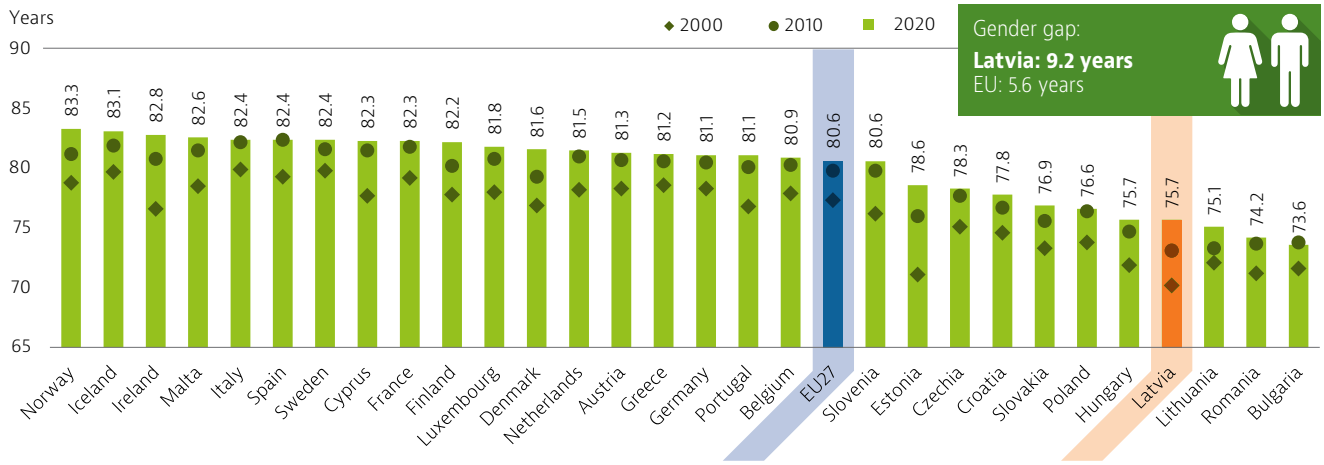
Latvians have one of the lowest levels of life expectancy in the EU

The life expectancy of the Latvian population has increased by more than five years over the past two decades, and reached 75.7 years in 2020. Despite a growth rate above the average for the EU as a whole, life expectancy in Latvia remains the fourth lowest in the EU after Bulgaria, Romania and Lithuania, and almost five years below the EU average of 80.6 years (Figure 1).

Moreover, COVID-19 temporarily interrupted the positive trend, as life expectancy did not increase between 2019 and 2020.

The gender gap in life expectancy is more than nine years – the second highest in the EU. On average, men lived only 70.9 years in 2020 compared to 80.1 years for women. This is largely due to the greater exposure among men to key risk factors for health – especially smoking and alcohol consumption.

Figure 1. Life expectancy at birth in Latvia is almost five years below the EU average

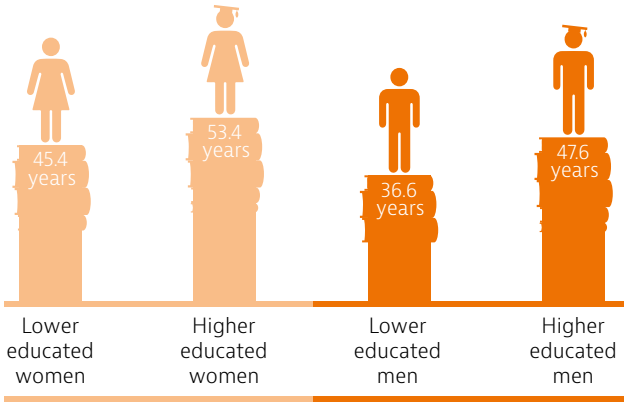


Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

Social inequalities due to education are pronounced

Inequalities in life expectancy in Latvia exist not only by sex but also by level of education. At age 30, the life expectancy of men with the lowest level of educational attainment is, on average, 11 years lower than for men with tertiary education, while for women the difference is 8 years (Figure 2). These gaps are much greater than the EU average for both sexes, and are largely explained by greater exposure to various risk factors among the least educated people. These include, for example, higher smoking rates and poorer nutritional habits (see Section 3).

Figure 2. The education gap in life expectancy is much greater than in the rest of the EU



Education gap in life expectancy at age 30:

Latvia:	8 years	Latvia:	11 years
EU18:	3.4 years	EU18:	6.9 years

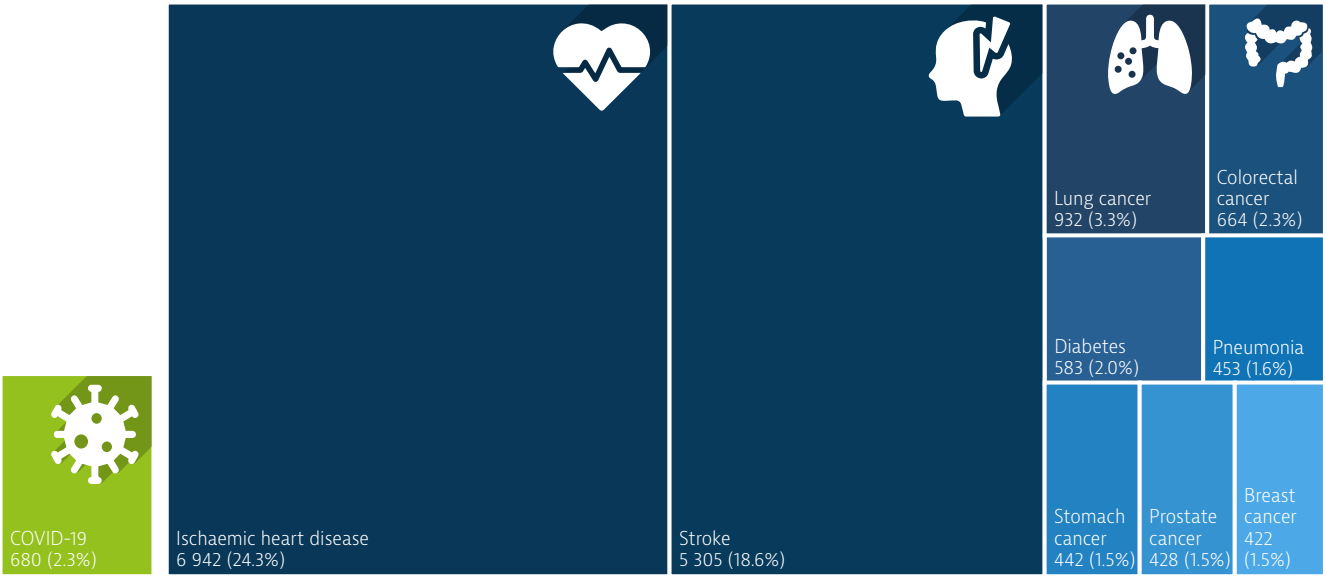
Note: Data refer to life expectancy at age 30. High education is defined as people who have completed tertiary education (ISCED 5-8), whereas low education is defined as people who have not completed secondary education (ISCED 0-2).
Source: Murtin et al. (2017) (data refer to 2012).

Cardiovascular diseases are the leading cause of death in Latvia

Despite reductions in mortality, ischaemic heart disease and stroke were still the main causes of death in Latvia in 2018. Lung cancer remained the most frequent cause of death by cancer, followed by colorectal cancer (Figure 3). The burden of mental ill health is also significant in Latvia: suicide is a major cause of death, particularly among men. Despite some progress in suicide prevention, Latvia recorded the fifth highest suicide rate in the EU in 2018.

In 2020, COVID-19 accounted for 680 deaths in Latvia (or 2.3 % of all deaths). This mortality rate was less than half the average across EU countries in 2020 (350 per million population compared with around 740 on average in the EU). In the first half of 2021, however, another 1 848 COVID-19 deaths were registered in Latvia. As a result, Latvia's cumulative mortality rate at the end of June 2021 (1 325 per million) was closer to the EU average at that time (1 559 per million population).

Figure 3. Ischaemic heart disease and stroke account for the majority of deaths in Latvia

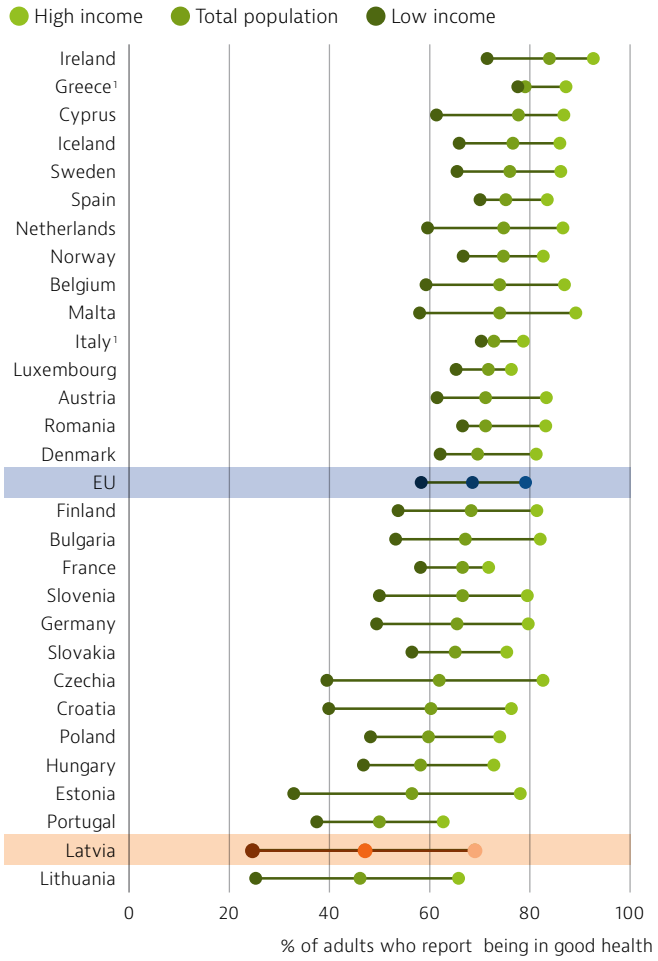


Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.
Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

Less than half the Latvian population reports being in good health

Only 47 % of the Latvian population reported being in good health in 2019 – a proportion substantially below the EU average (69 %). Moreover, the gap in self-reported health by income level in Latvia is very large (Figure 4). In 2019, 69 % of the population in the highest income quintile reported being in good health, compared to only one quarter (25 %) of those in the lowest – one of the largest gaps in the EU.

Figure 4. Inequalities in self-reported health by income level are substantial in Latvia



Note: 1. The shares for the total population and the population on low incomes are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2019).

More than two in five adults have a chronic condition

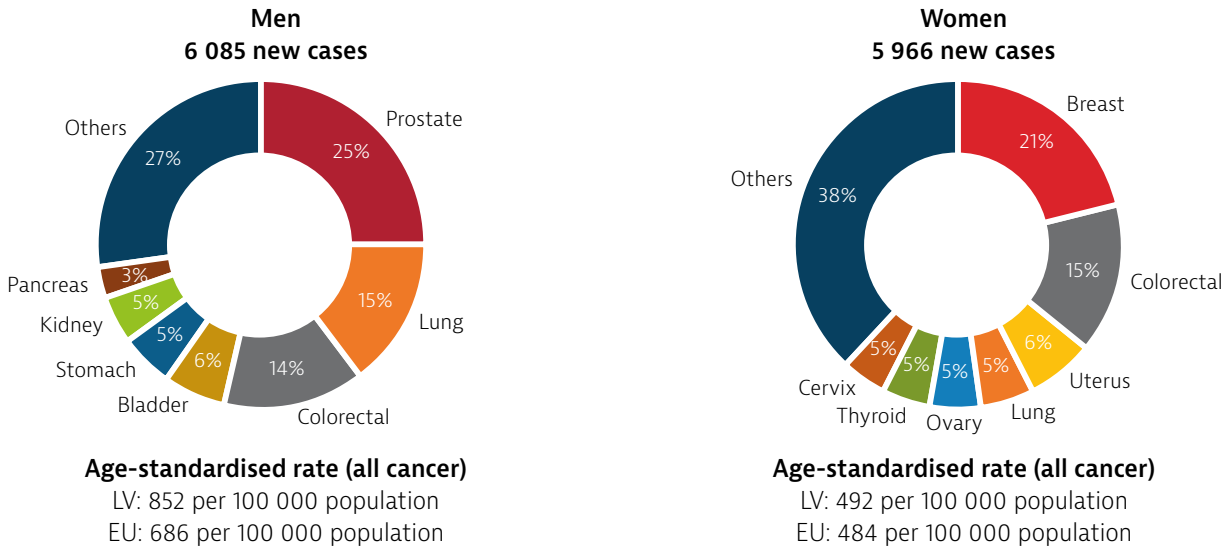
More than 40 % of adults reported having at least one chronic condition in 2019 – a proportion above the EU average (36 %), according to EU-SILC. Many of these chronic health problems increase the risk of severe complications from COVID-19. As with self-reported health, there is a substantial gap in the prevalence of chronic conditions by income group: more than 60 % of Latvian adults in the lowest income group reported having at least one chronic condition, compared to only 24 % of those in the highest. This gap is considerable larger than that for the EU as a whole, where on average 44 % of people in the lowest income group have a chronic condition, compared to 29 % in the highest.

Cancer incidence and mortality are above the averages for the EU as a whole

According to the latest estimates from the Joint Research Centre based on incidence trends from previous years, around 12 000 new cases of cancer and nearly 6 000 deaths from cancer were expected in Latvia in 2020. Both incidence and mortality rates from cancer in Latvia are higher than the EU averages. The age-standardised rate is 288 deaths from cancer per 100 000 population compared to 260 deaths in the EU on average. Cancer mortality is particularly high among Latvian men, at 434 per 100 000 men compared to 354 per 100 000 in the EU.

Figure 5 shows that the main cancer sites among men are prostate (25 %), lung (15 %) and colorectal (14 %), while among women breast cancer is the leading cancer (21 %), followed by colorectal (15 %) and uterus cancer (6 %).

Figure 5. More than 12 000 people in Latvia were expected to be diagnosed with cancer in 2020



Note: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

3 Risk factors

Lifestyle and environmental risk factors account for nearly half of all deaths in Latvia

The high mortality rates and poor health status of the Latvian population are largely linked to high prevalence of behavioural risk factors. It is estimated that 43 % of all deaths in Latvia can be attributed to the combination of dietary risks, tobacco smoking, alcohol consumption and low physical activity (Figure 6).

One quarter of all deaths in 2019 (6 600 deaths) were related to dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption), which is well above the EU average (17 %). Tobacco consumption, including direct and second-hand smoking, was responsible for an estimated 15 % (4 100) of all deaths. About 6 % of deaths were linked to alcohol consumption and 4 % to low physical activity. Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for about 4 % of all deaths.

Figure 6. The majority of deaths in Latvia can be linked to lifestyle-related risk factors

Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Men are more likely to smoke in Latvia than in most EU countries

Smoking remains a major public health issue in Latvia. Among adults, more than one in five (23 %) reported smoking daily in 2019, compared to less than 20 % in the EU as a whole (Figure 7). There is a large gender gap in smoking, with smoking rates nearly three times as high among Latvian men than women (35 % compared to 12 %). The proportion of men smoking daily was the second highest in the EU in 2019. Smoking among adolescents is also an important public health issue in Latvia: 23 % of 15-year-olds reported that they had smoked during the past month in 2018 – a higher proportion than the EU average of 18 %.

Excessive alcohol consumption is an ongoing challenge in Latvia

Latvia reports the highest level of alcohol consumption per adult in the EU, and it was more than 25 % above the EU average in 2019. Heavy alcohol consumption is much more frequent among men, with almost 1 in 4 reporting at least one episode of binge drinking[1] at least once a month in 2019, compared with 1 in 15 women. On a more positive note, the proportion of 15-year-olds who reported having been drunk more than once in their life has come down: while in 2010, 47 % reported repeated drunkenness, in 2018, the rate was 25 % – only slightly above the EU average (22 %).

Obesity rates are high

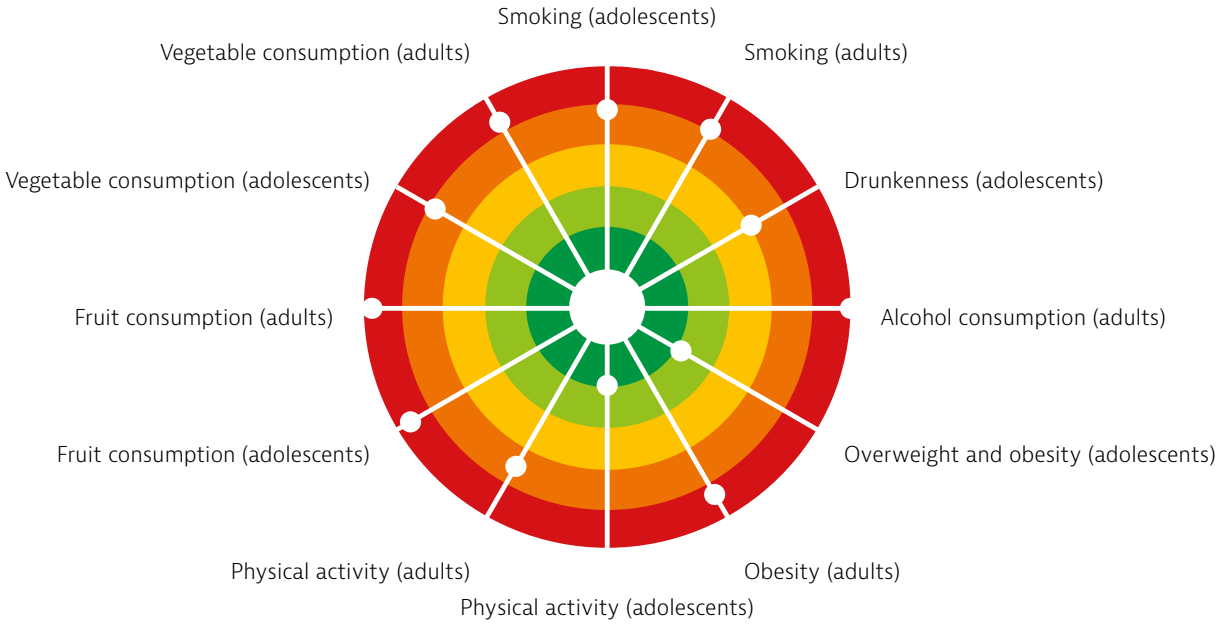
The obesity rate in Latvia is well above the EU average. In 2019, 22 % of adults were obese – more than six percentage points above the EU average. Poor nutritional habits are one factor explaining the high rate: in 2019, 65 % of adults reported consuming less than one piece of fruit daily, and 60 % reported the same with respect to vegetables (see Figure 7).

In addition, only three in five reported engaging in at least moderate physical activity each week. Adolescent Latvians fare better, with below-average obesity rates and higher levels of physical activity.

Socioeconomic inequality contributes to health risks

Many behavioural risk factors in Latvia are more common among people with lower levels of education and income. In 2014, 24 % of adults who had not completed secondary education smoked daily, compared to only 14 % among those with tertiary education – a greater gap than in most EU countries. The education gap in obesity rates is smaller: in 2019, 20 % of people without secondary education and a similar percentage (19 %) of those with higher education were obese. The higher prevalence of some risk factors among socially disadvantaged groups contributes to inequalities in health and life expectancy.

Figure 7. Several behavioural risk factors are more prevalent in Latvia than in most EU countries



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; OECD Health Statistics, EHIS 2014 and 2019 for adults indicators.

1. *Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.*

4 The health system

Latvia has a national health service-type health system with strong government stewardship

The National Health Service (NHS) in Latvia has universal population coverage, general tax-financed health care provision and a purchaser–provider split. The Ministry of Health is responsible for defining national health policies and regulations. It also regulates public health, while the Centre for Disease Prevention and Control (CDPC) coordinates and implements public health activities.

The NHS is the main purchaser of publicly funded health services in Latvia and is responsible for implementation of policies developed by the Ministry of Health. Providers contracting with the NHS tend to be predominantly private in the case of primary care; public and private in the case of secondary care, with public ownership concentrated mainly at the municipal level; and predominantly public in the case of tertiary care, with ownership concentrated at the national level. Latvia's response to COVID-19 benefited from established structures and plans (Box 1).

Box 1. Several pre-existing structures drove Latvia's COVID-19 response

The highest-level coordination body of Latvia's COVID-19 response is the Crisis Management Council, headed by the Prime Minister. It coordinates activities of national and local governments and takes decisions on issues such as declaring a state of emergency or closing national borders. The conditions for establishment of the Crisis Management Council were set out by the 2000 Law on National Security and specified by the 2011 Regulation of the Crisis Management Council. The Council has previously been convened to manage natural disasters such as floods and fires.

The health sector-specific emergency response is coordinated by the State Operational Medical Commission, the purpose of which is to ensure coordination of testing, tracing and treatment in the country. The composition of the Commission is approved by the Cabinet of Ministers, and includes representatives of the NHS, CDPC, Emergency Medical Service (an ambulance service), State Agency of Medicines, National Blood Donor Centre, Health Inspectorate, National Forensic Medicine Expertise Centre and university hospitals. National Disaster and Hospital Disaster Medical Plans existed prior to the pandemic and laid the foundations for the response.

The main bodies involved in the response are the Ministry of Health, the CDPC (reporting to the WHO and EU; contact tracing), the Emergency Medical Service (coordination and transport of hospitalisations) and the NHS (organising, planning and paying for health care services; central procurement of medical devices and goods, including individual protective equipment for health care institutions).

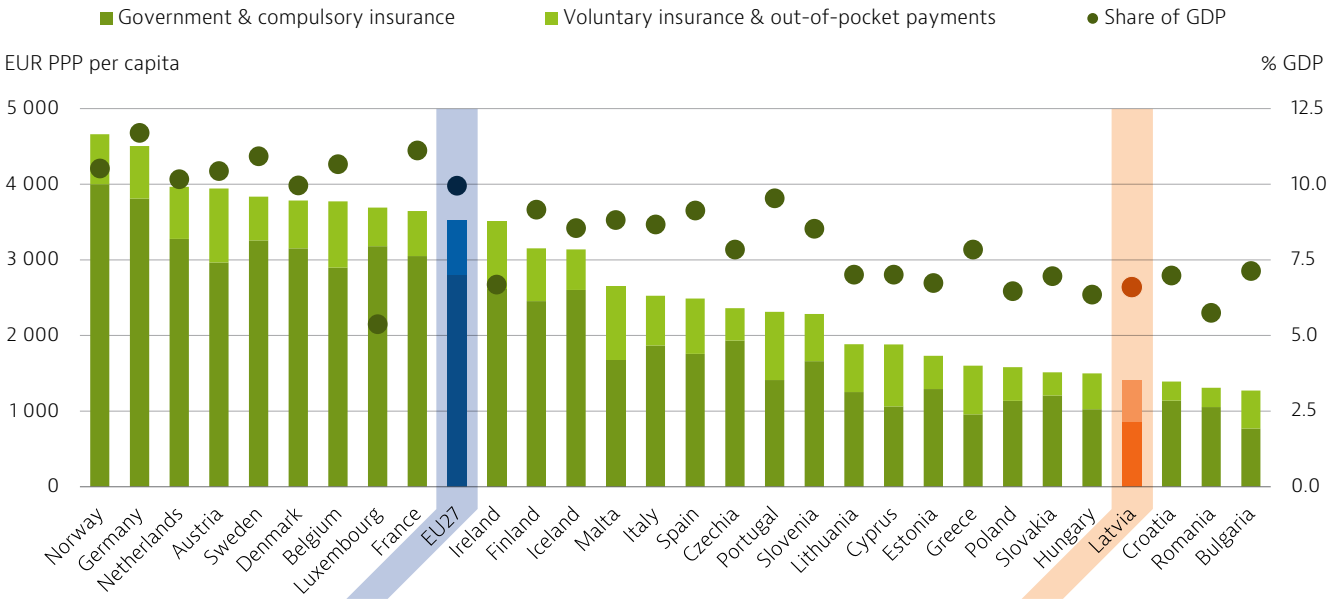
Source: WHO Regional Office for Europe, European Commission, European Observatory on Health Systems and Policies (2021)

Health spending has increased but the system remains underfunded

Although health expenditure per capita has increased by 75 % since 2010, at EUR 1 409 (adjusted for differences in purchasing power) it remained the fourth lowest in the EU after Bulgaria, Romania and Croatia in 2019 (Figure 8). When measured as a proportion of GDP, health spending in Latvia increased more strongly than in all other EU countries: from 5.5 % in 2014 to 6.6 % in 2019. However, it remains considerably below the average for the EU as a whole (9.9 %).

Only 61 % of health expenditure came from public funding sources in 2019 – a considerably lower proportion than both the average for the EU as a whole (80 %) and the shares in neighbouring countries (66 % in Lithuania and 74 % in Estonia). Most public resources are raised through general taxation. In 2018 the social security contribution rate was increased by one percentage point (split equally between employers and employees), and the additional revenue was earmarked for health care. While this additional charge on wages was abolished in 2021, the amount of social security revenues earmarked for health care remained the same at 2.78 %.

Figure 8. Despite increases over the past decade, health spending in Latvia remains among the lowest in the EU



Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

Out-of-pocket spending on health is the second highest in the EU

Out-of-pocket (OOP) spending is very high in Latvia, accounting for 36 % of total health expenditure in 2019 – more than twice the EU average (15 %), with negative consequences for accessibility of health care (see Section 5.2). Although the health system provides coverage to the entire population and pays for a basic benefits package, patients have to pay user charges for almost all types of services and goods – most importantly for outpatient pharmaceuticals. In addition, OOP payments are related to the limited scope of the benefits package, which excludes, among others, dental care for adults and most rehabilitative and physiotherapy services. Furthermore, given the shortage of public funding for contracted services, patients often make direct private payments for care provided by public and private providers in order to avoid waiting lists.

Voluntary health insurance (VHI) plays a marginal role in Latvia and accounts for only 3.6 % of health expenditure.

Latvia has shifted spending from inpatient care to outpatient care

Compared to other EU countries, Latvia has been relatively successful in shifting service provision away from inpatient care to outpatient care. As a result, the proportion spent on outpatient care has increased by almost 30 % since 2010. The proportion spent on pharmaceuticals and medical devices in Latvia (28 %) is the fifth highest in the EU and is far above the average for the EU as a whole (18 %), although this is due in part to lower overall health expenditure. In absolute terms, health spending on pharmaceuticals is below average (Figure 9). The government increased funding for health considerably to respond to COVID-19 in 2020 (Box 2).

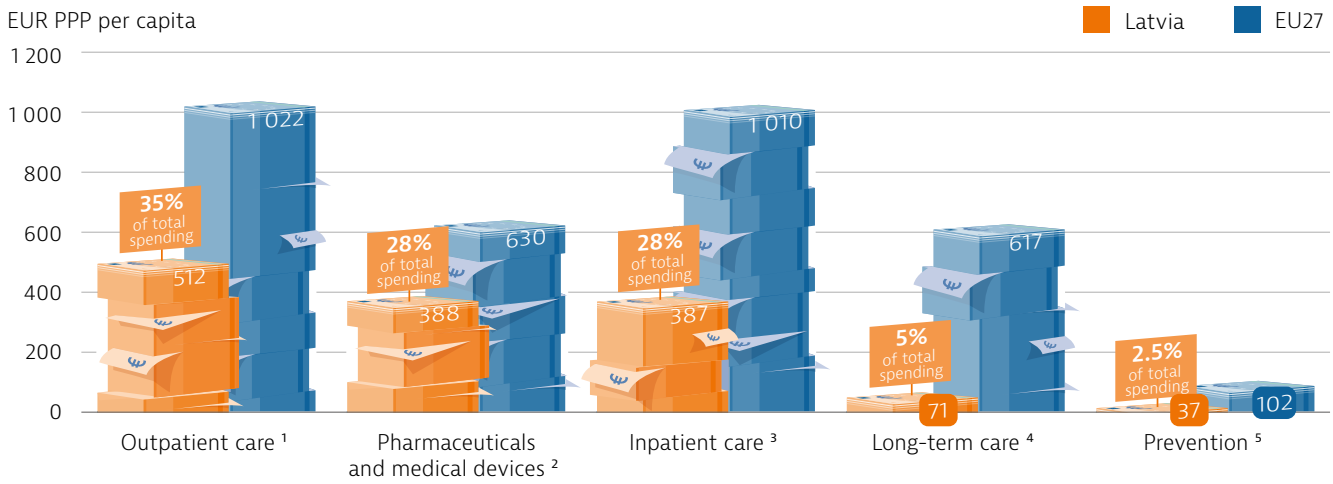
Box 2. The government allocated more than EUR 290 million to the COVID-19 response in 2020

In late 2020, the government decided to allocate an additional budget of EUR 254 million to health and public health services, which is more than 20 % of the total state health care expenditure. As the second wave of COVID-19 was much more important in Latvia than the first wave, this was considerably more than the EUR 36 million that had been allocated in early 2020.

Resources in the financial package for the second wave were mostly used on increasing laboratory capacities (EUR 66 million), purchasing personal protective equipment (EUR 53 million), improving medical infrastructure (EUR 50 million), funding bonus payments for health professionals (EUR 33 million), improving access to services (EUR 25 million), supporting recalculation of service payment tariffs (EUR 17 million) and reducing the mental health impact of the pandemic (EUR 7 million).

Source: WHO Regional Office for Europe, European Commission, European Observatory on Health Systems and Policies (2021)

Figure 9. Outpatient care and pharmaceuticals absorb most of the Latvian health care budget



Note: The costs of health system administration are not included. 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes only the outpatient market; 3. Includes curative-rehabilitative care in hospital and other settings; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

Shortages of health care personnel are aggravated by uneven geographical distribution

Health workforce shortages are an important problem in Latvia (Figure 10). The number of practising doctors was 3.3 per 1 000 population in 2019 – significantly below the average for the EU as a whole (3.9 per 1 000), while the number of nurses was only about half the EU average and one of the lowest in the EU. In addition, health workers are highly concentrated in urban areas, which gives rise to equity and accessibility issues for residents living in rural areas (see Section 5.2).

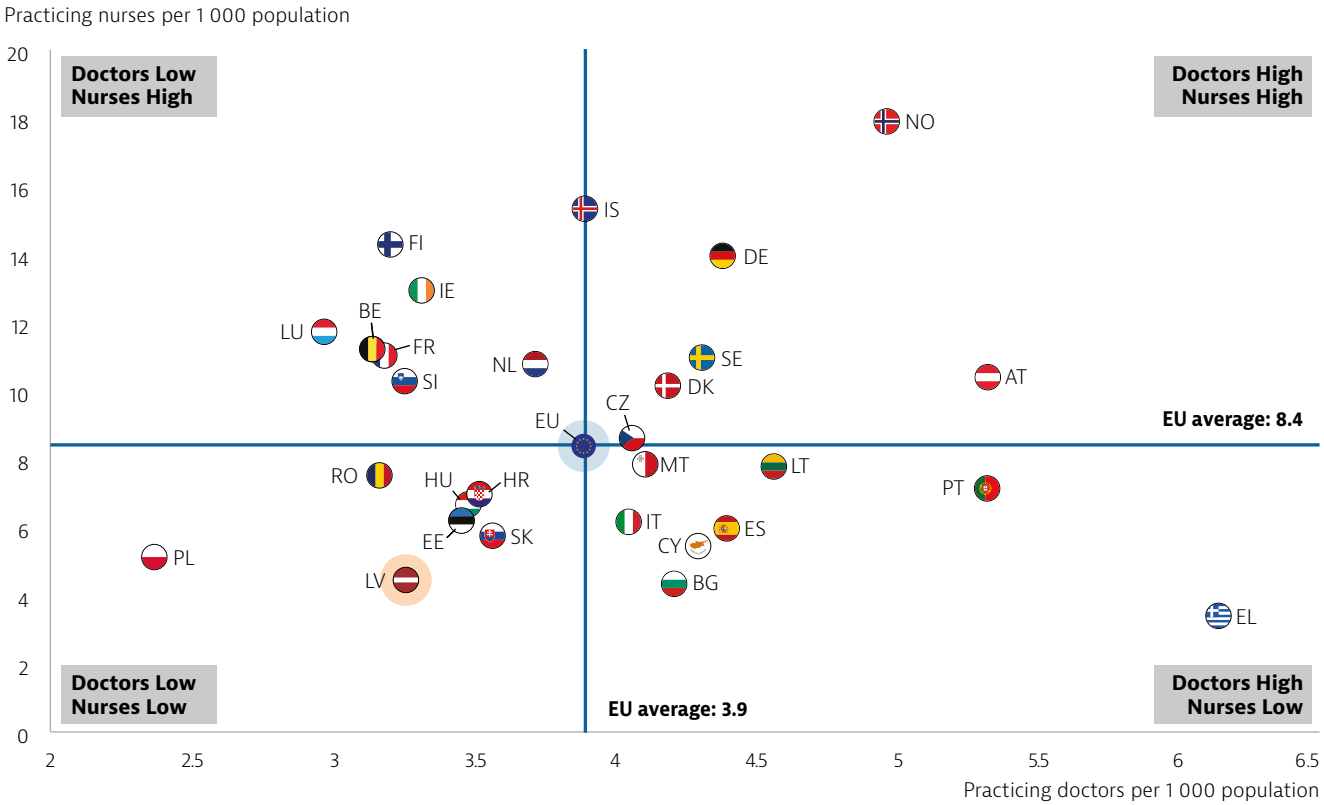
Furthermore, low salaries for medical staff in the public sector drive some health care professionals to the private sector. Aiming to address workforce shortages, Latvia considerably increased capacity for medical training: the number of medical graduates increased from 179 in 2010 to 450 in 2018. In addition, wages of medical practitioners have increased on average between 10 % and 20 % per year since 2018. Also, since 2018, an EU-funded project has provided financial incentives to attract medical practitioners to work in regions outside Riga. However, less focus has been given to increasing nursing capacity, where the number of graduates has remained more or less stable since 2010.

Both private hospital care and primary care have grown in recent years

As a result of an institutional centralisation process and a shift away from hospital to outpatient care, the numbers of hospitals and hospital beds decreased sharply between 2000 and 2010. Since then, they have remained relatively stable, and in 2019 the Latvian hospital care system had a capacity of 5.4 hospital beds per 1 000 population – similar to EU average of 5.3 per 1 000. Because of funding limits, the NHS contracts only a certain number of services per year. Combined with low service tariffs in the public sector, this has led to long waiting times (see Section 5.2) and a substantial expansion of a parallel private health care sector. The number of private, for-profit hospital beds – distributed across a large number of small hospitals – grew from just 2 % to 10 % of the total between 2000 and 2019.

Almost all Latvians are registered with a general practitioner (GP), who acts as the main point of entry into the health care system and as the gatekeeper for most secondary ambulatory and hospital care. Several reforms have aimed to strengthen primary care. Between 2010 and 2016 the number of primary care practices went from 361 to 1 275. In addition, EU structural funds have helped support the establishment of larger multi-professional primary care centres with extended opening hours.

Figure 10. The numbers of doctors and nurses in Latvia are far below EU averages



Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Eurostat Database (data refer to 2019 or the nearest year).

5 Health system performance

5.1 Effectiveness

Many deaths in Latvia could be avoided through better prevention and health care

In 2018, Latvia had the second highest mortality rate from both preventable and treatable causes in the EU (Figure 11).
Almost 6 000 deaths could have been avoided through effective public health and prevention, and a further 3 500 deaths through more appropriate and timely health care. This highlights a substantial need to develop more effective public health policies and to invest in improving the quality of the health care system.

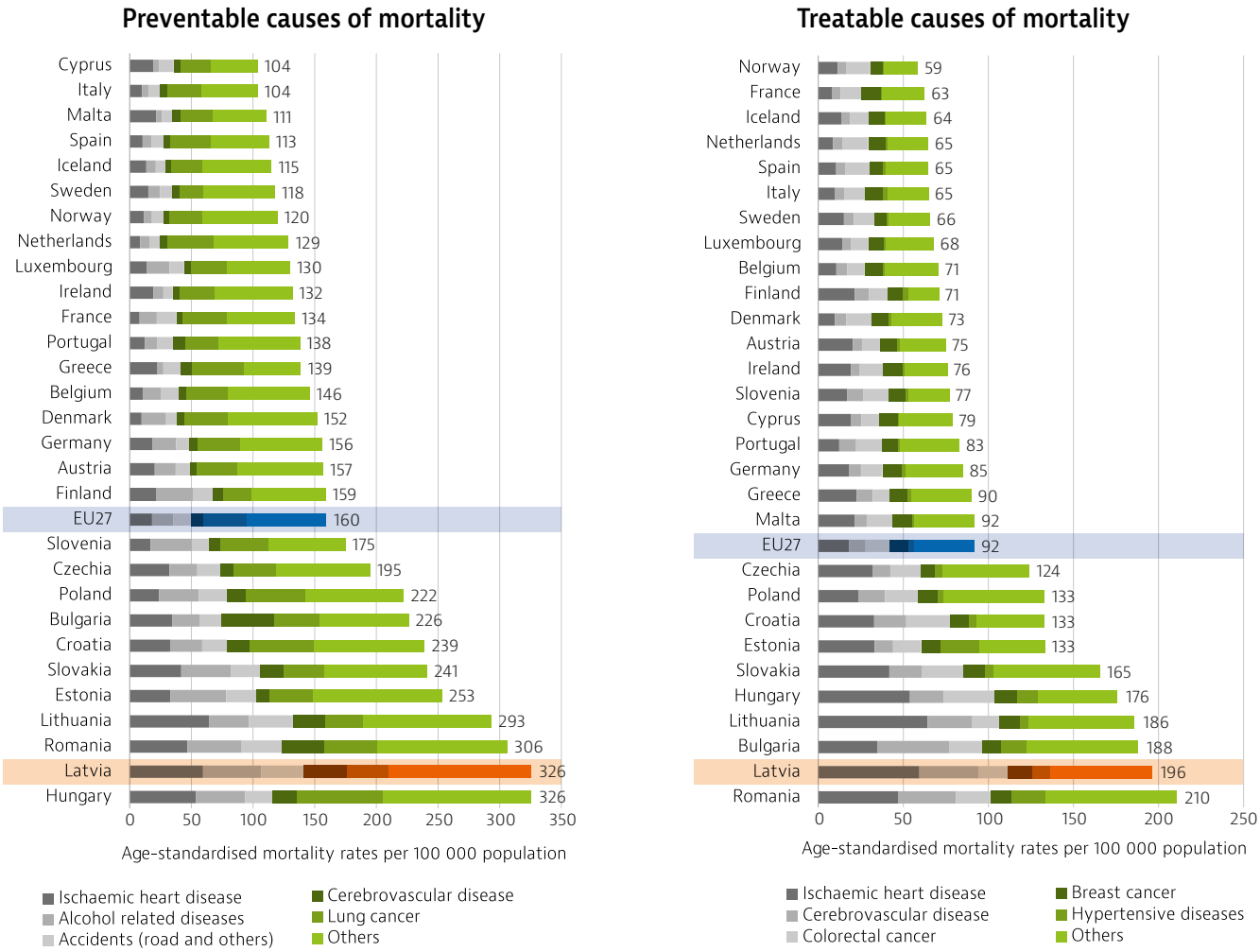
Latvia has implemented policies to improve population health, but resources are lacking

As seen in Section 3, nearly half of all deaths in Latvia are attributed to behavioural risk factors, including alcohol, smoking, poor nutrition and physical inactivity.

To address these, the Ministry of Health has a clear strategic focus on prevention and health promotion. This includes the new National Action Plan on the Consumption of Alcoholic Beverages and Limitation of Alcoholism 2020-22, adopted by the Cabinet of Ministers on 30 July 2020, which calls for tougher restrictions on the advertising and availability of alcoholic beverages, and the Latvian Public Health Strategy 2021-27, which is currently being developed.

However, limited resources could continue to hamper progress on public health. Latvia spends less than other EU countries on public health and prevention, at only 2.5 % of its – already lower than average – health care budget (see Section 4), compared to 2.9 % on average in the EU. GPs and municipalities are expected to play a key role in delivering the public health strategy, but both appear overstretched and under-resourced (OECD, 2020).

Figure 11. Latvia has the second highest mortality rates from both preventable and treatable causes in the EU



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2018, except for France 2016).

Latvia expanded state coverage of flu vaccinations during the COVID-19 pandemic

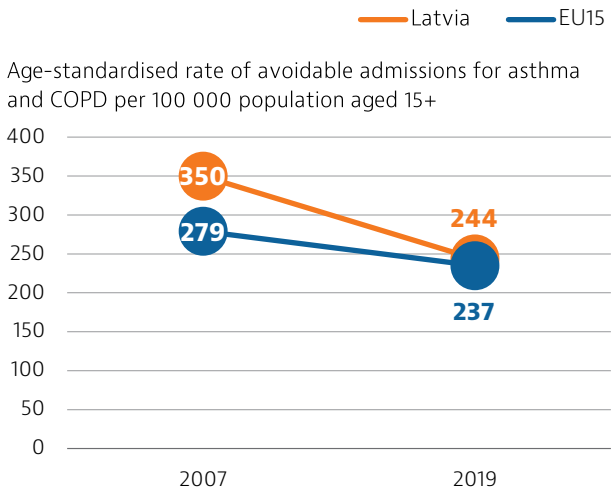
The COVID-19 pandemic raised the issue of the importance of vaccination against seasonal influenza, to avoid another virus putting additional pressures on hospitals. Historically, Latvia has had low coverage of flu vaccination among the elderly: in 2019, fewer than 12 % of people aged 65 and over were immunised against seasonal flu, compared to an EU average of 42 %. However, the total number of people vaccinated is increasing: 31 533 people were vaccinated against influenza in 2018/2019, and this rose to 43 110 in 2019/2020.

Because of COVID-19, in 2020 the population groups for which the state covers the cost of the influenza vaccine in full were expanded to include seniors over the age of 65, people suffering from chronic diseases, residents and employees of long-term social care institutions, and medical and support staff – in addition to pregnant women and children aged between 6 and 24 months who were already fully covered.

Latvia has focused on improving primary care effectiveness

In the past decade, Latvia has focused on improving primary care effectiveness. While in 2007 the rate of avoidable admissions for asthma and chronic obstructive pulmonary disease was relatively high, it is now around the EU average, reflecting the decreasing prevalence of these conditions in Latvia, as well as improvements in disease management interventions in outpatient settings (Figure 12). Several initiatives have been implemented to strengthen primary care, including development of quality indicators. However, there have been disagreements between GPs and the NHS about the appropriateness of these indicators.

Figure 12. Avoidable admissions for asthma and chronic obstructive pulmonary disease have decreased in recent years



Source: OECD Health Statistics 2021.

Despite significant improvements, cancer screening rates remain low

As mentioned in Section 2, cancer is a major public health issue in Latvia. Since 2008, considerable progress has been made in increasing the uptake of breast cancer screening among women. Nevertheless, the screening rate remains low – at 39 % compared to an EU average of 59 % in 2019. Other cancer screening rates show a similar picture: despite having increased significantly in recent years, only 40 % of Latvian women aged 20-69 had been screened for cervical cancer within the past two years in 2019, compared to 58 % on average in the EU. Similarly, in 2019 only 32 % of Latvians aged 50-74 years reported having had a colorectal screening test in the past three years, compared to the EU average of 41 %.

The relatively low uptake of cancer screening in Latvia is reflected in below-average five-year survival rates (Figure 13). While for some cancers Latvia does as well or better than the EU average, the five-year survival rate for breast, cervical and colon cancer is lower than the EU average. This emphasises the importance of stepping up efforts to increase cancer screening rates, as early detection can significantly improve the prognosis for these types of cancer (Box 3).

Box 3. Latvia has promoted cancer screening uptake

For at least a decade, since the introduction in 2009 of three national cancer screening programmes (breast, cervical and colorectal), the government has sought to improve participation in screening programmes.

- Information campaigns were organised twice, in 2017 and 2019, to increase public awareness of cancer and cancer screening.
- Educational seminars were organised by the CDPC in workplaces. These were designed to raise awareness of cancer screening and to motivate employees to attend preventive health check-ups.
- Financial incentives for GPs were explored in a pilot programme in 2018 and 2019, where GPs were awarded a fee if they managed to increase the screening rate among their registered population.

Improving access to and quality of screening is also one of the key action areas of the European Commission's Europe's Beating Cancer Plan.
Source: WHO Regional Office for Europe, European Commission, European Observatory on Health Systems and Policies (2021)

Sources: European Commission (2021a); OECD (2020).

Figure 13. Five-year survival rates for cancers in Latvia are below the EU average

Prostate cancer	Childhood leukaemia	Breast cancer	Cervical cancer	Colon cancer	Lung cancer
Latvia: 90 %	Latvia: 84 %	Latvia: 77 %	Latvia: 54 %	Latvia: 49 %	Latvia: 18 %
EU23: 87 %	EU23: 85 %	EU23: 82 %	EU23: 63 %	EU23: 60 %	EU23: 15 %

Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

5.2 Accessibility

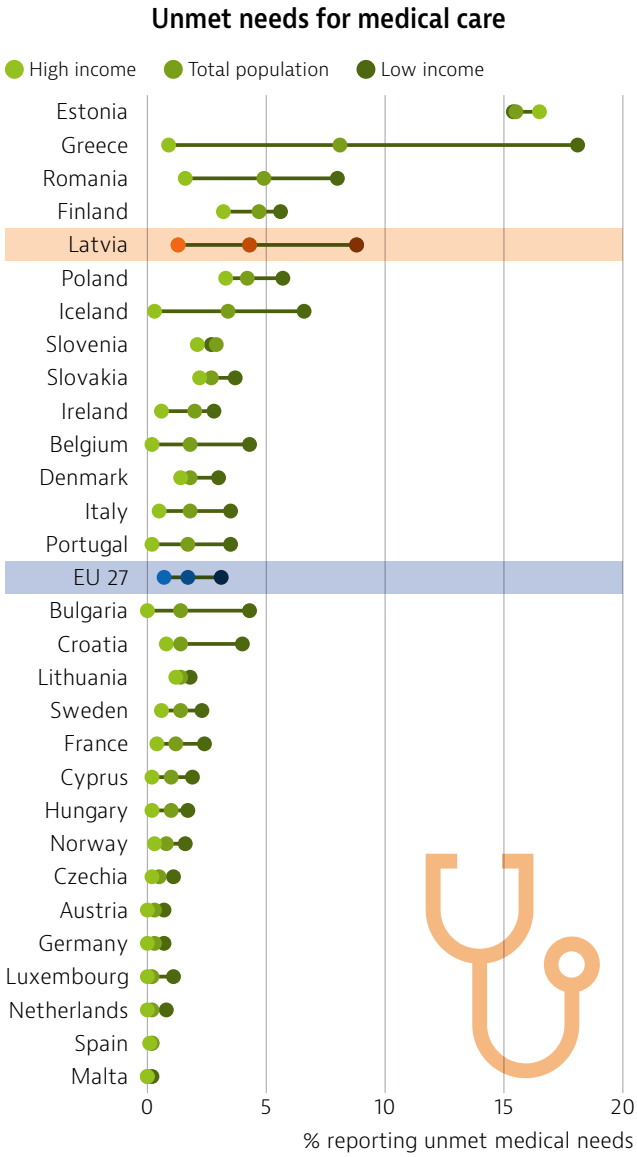
A substantial share of the Latvian population cannot access the care they need

The proportion of the Latvian population reporting unmet needs for medical treatment is among the highest in Europe. In 2019, 4.3 % of the population reported having forgone medical care due to costs, distance to travel or waiting times – well above the EU average of 1.7 % (Figure 14). Moreover, lower income groups were disproportionally affected: Latvians in the lowest income quintile were much more likely to report unmet needs for medical care (8.8 %) than those in the highest (1.3 %). During the first 12 months of the COVID-19 pandemic, 29 % of Latvians reported unmet medical care needs in the Eurofound (2021) survey[2].

Access to basic medical care is enshrined in the Latvian constitution, but only a small proportion is publicly funded

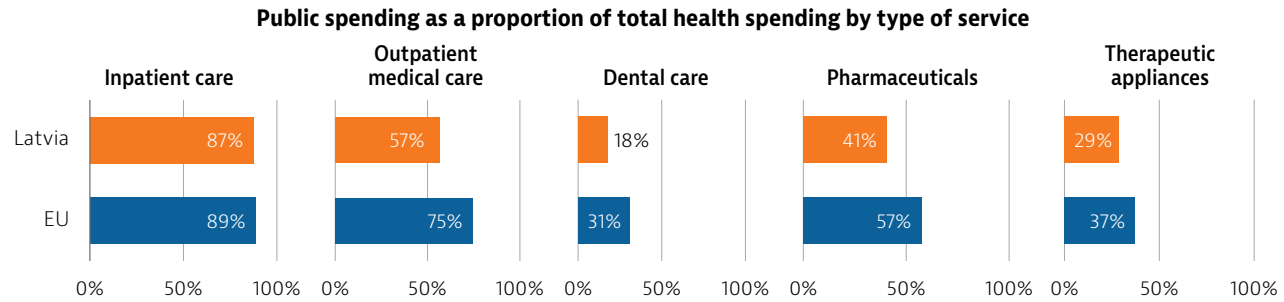
The Latvian constitution guarantees universal population health care coverage, declaring that "the state shall protect human health and guarantee a basic level of medical assistance for everyone". However, the benefits package in Latvia is limited compared to other EU countries, as it excludes services such as dental care for adults, some rehabilitation and physiotherapy, medical check-ups for occupational purposes, hearing aids for adults, sight correction, psychotherapy and pregnancy termination if there are no medical or social grounds (Behmane et al., 2019). Moreover, all health care services – such as GP visits, specialist visits, hospital stays and pharmaceuticals – are subject to user charges. These range from EUR 0.71 per prescription for drugs that are fully reimbursed to EUR 35.57 for an MRI examination. As a result, the public health care system covers a smaller proportion of health care costs across all types of care than the average share in the EU (Figure 15).

Figure 14. Latvians with low incomes report high unmet medical needs



Note: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2019, except Iceland 2018).

Figure 15. In Latvia a relatively small share of health care cost is publicly funded



Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

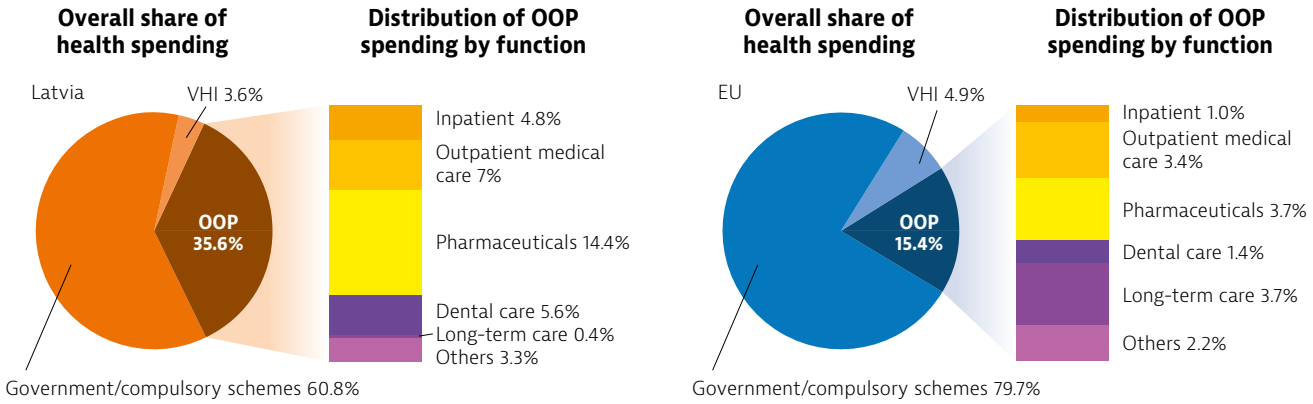
2. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

High out-of-pocket expenditure results in catastrophic health spending for many Latvians

In 2019, 36 % of health expenditure in Latvia was paid for out of pocket, which is the second highest level in the EU after Bulgaria, and far above the average for the EU as a whole (15 %). The majority of OOP spending goes on outpatient pharmaceuticals (Figure 16). Current reimbursement mechanisms mean that patients face percentage co-payments (rather than a flat rate), and there is no cap on OOP payments for outpatient pharmaceuticals.

On top of this, some essential medicines such as aspirin (anticoagulant), glibenclamide (antidiabetic), penicillin and erythromycin (antibiotics) are not reimbursed at all (OECD, 2020). A blueprint of policy actions to increase the affordability of medicines at the EU level was developed by the European Commission in its recently adopted pharmaceutical strategy for Europe (Box 4).

Figure 16. Latvia has high out-of-pocket expenditure compared to the EU average



Note: The EU average is weighted. VHI = voluntary health insurance, which also includes other voluntary prepayment schemes.
Sources: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).

Box 4. The European Commission has adopted a pharmaceutical strategy to improve access in Europe

In November 2020, the European Commission adopted a pharmaceutical strategy for Europe to ensure that patients have access to innovative and affordable medicines and to support the competitiveness, innovative capacity and sustainability of the EU's pharmaceutical industry. The strategy is expected to allow Europe to cover its pharmaceutical needs, including in times of crisis, through robust supply chains. It is formulated around four pillars:

- Ensuring access to affordable medicines for patients, and addressing unmet medical needs (e.g. in the areas of antimicrobial resistance, cancer and rare diseases)
- Supporting competitiveness, innovation and sustainability of the EU's pharmaceutical industry and the development of safe, effective and greener medicines
- Enhancing crisis preparedness and response mechanisms, and addressing security of supply
- Ensuring a strong EU voice in the world, by promoting a high level of quality, efficacy and safety standards

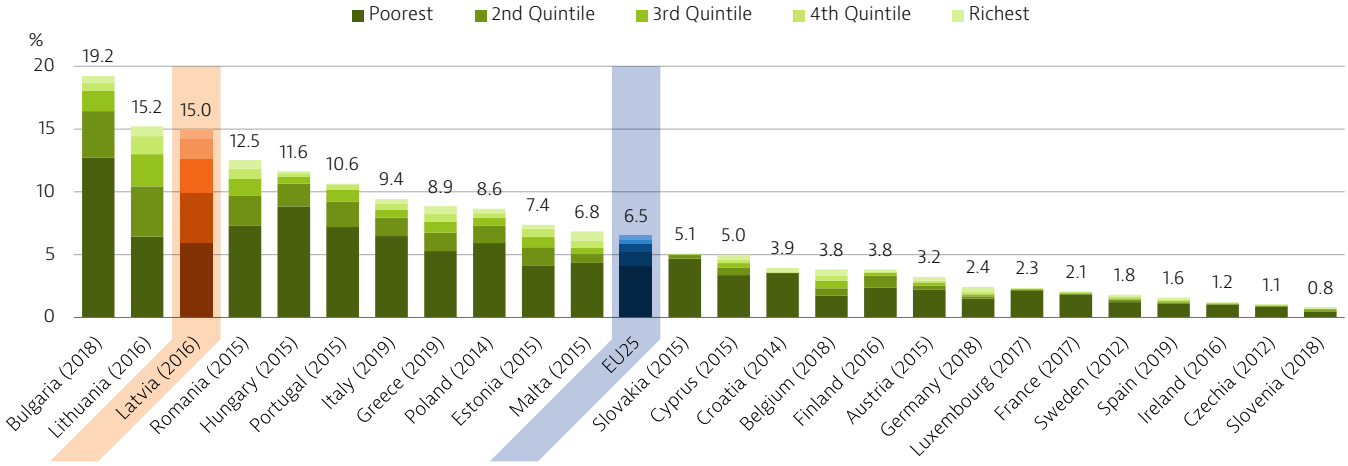
Adoption of the strategy marks the beginning of a process and the launch of an ambitious agenda of legislative and non-legislative action over the coming years, including a revision of the basic pharmaceutical legislation with a view to making this framework future-proof and innovation friendly; a revision of the regulations on medicines for children and rare diseases; and enhanced co-operation between national authorities on pricing, payment and procurement policies, with a view to improving the affordability and cost–effectiveness of medicines.

Source: European Commission (2020).

As a result of the high OOP payments, the incidence of catastrophic health spending[3] is high in Latvia (Figure 17): in 2016, it was experienced by 15 % of households, and the costs of outpatient medicines were almost exclusively responsible (OECD, 2020).

Compared to other countries where primarily only the poorest households experienced catastrophic health spending, in Latvia even households with a higher income are affected.

Figure 17. Catastrophic health spending in Latvia is common across income groups



Note: The EU average is unweighted.
Source: WHO Regional Office for Europe data, 2021.

The availability of public health care services is limited

Even when services are included in the benefits package, access to these is limited (Behmane et al., 2019). Publicly funded health services are subject to annual quotas; once these are met, patients have to either wait until the following year or cover the costs privately. This is reflected in both lower rates of certain procedures (for example, the number of total knee or hip replacements) and higher waiting times (for example, for cataract surgery). To address the issue of waiting times, the NHS has committed to allocate additional funding to pay for more services. However, for a number of public services, the NHS tariffs are still below the cost of the service. This results in fewer specialists willing to provide the service, which has an impact on the availability and quality of the services.

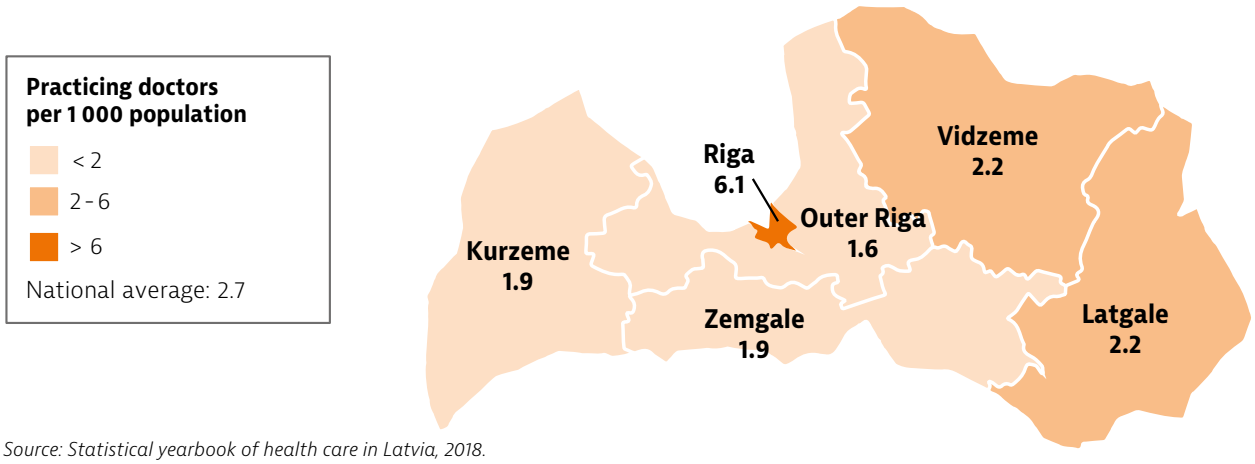
At the beginning of the COVID-19 pandemic, all residents were eligible for a state-funded COVID-19 test, even without symptoms. However, as demand began to outgrow supply, in October 2020 a doctor's referral was made mandatory to receive a free test. This temporary measure was lifted in January 2021 in order that anyone with symptoms of the disease could get a state-funded test.

Latvia is working to address the uneven geographical distribution of health professionals

Health professionals are concentrated in urban areas, creating barriers to access for people living in rural areas (Behmane et al., 2019). In 2018, the ratio of practising medical doctors per 1 000 population was more than three times higher in the Riga area than in rural regions (Figure 18). To improve access to care in rural areas, Latvia has introduced a number of policies. GPs practising in underserved areas receive monthly bonuses, a higher capitation rate and other financial incentives. Since April 2015, medical universities have been required to give priority to applicants who have agreed to practise in a rural area on completion of their training (Behmane et al., 2019; OECD, 2020).

3. *Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).*

Figure 18. The distribution of doctors across regions is severely unbalanced



Source: Statistical yearbook of health care in Latvia, 2018.

5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic[4]. As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Latvia in 2020 and 2021, as in most other EU countries. The measures taken to contain the pandemic also had an impact on the economy, as GDP fell by 3.6 % and unemployment increased from 7.4 % at the start of 2020 to 8.8 % by the end.

After a relatively mild first wave of COVID-19, cases in Latvia spiked at the end of 2020

While many European countries were dealing with the devastating effects of the first wave of COVID-19 infections in the spring of 2020, Latvia was largely spared (Figure 19). The country's first cases were reported in March 2020. At the peak of the first wave, Latvia saw 12 cases per 100 000 population per week – below the EU average of 33 per 100 000 and well below some of the hardest-hit countries, where rates were more than double that.

Nevertheless, Latvia was quick to implement containment strategies (OECD/EU, 2020). Despite the fact that infection rates were lower than in many other countries, the government declared a state of emergency in March 2020, while also banning public gatherings, closing schools, restricting international travel and introducing a two-metre distancing rule and self-isolation requirements for returning travellers, as well as people who had been in contact with a confirmed COVID-19 case.

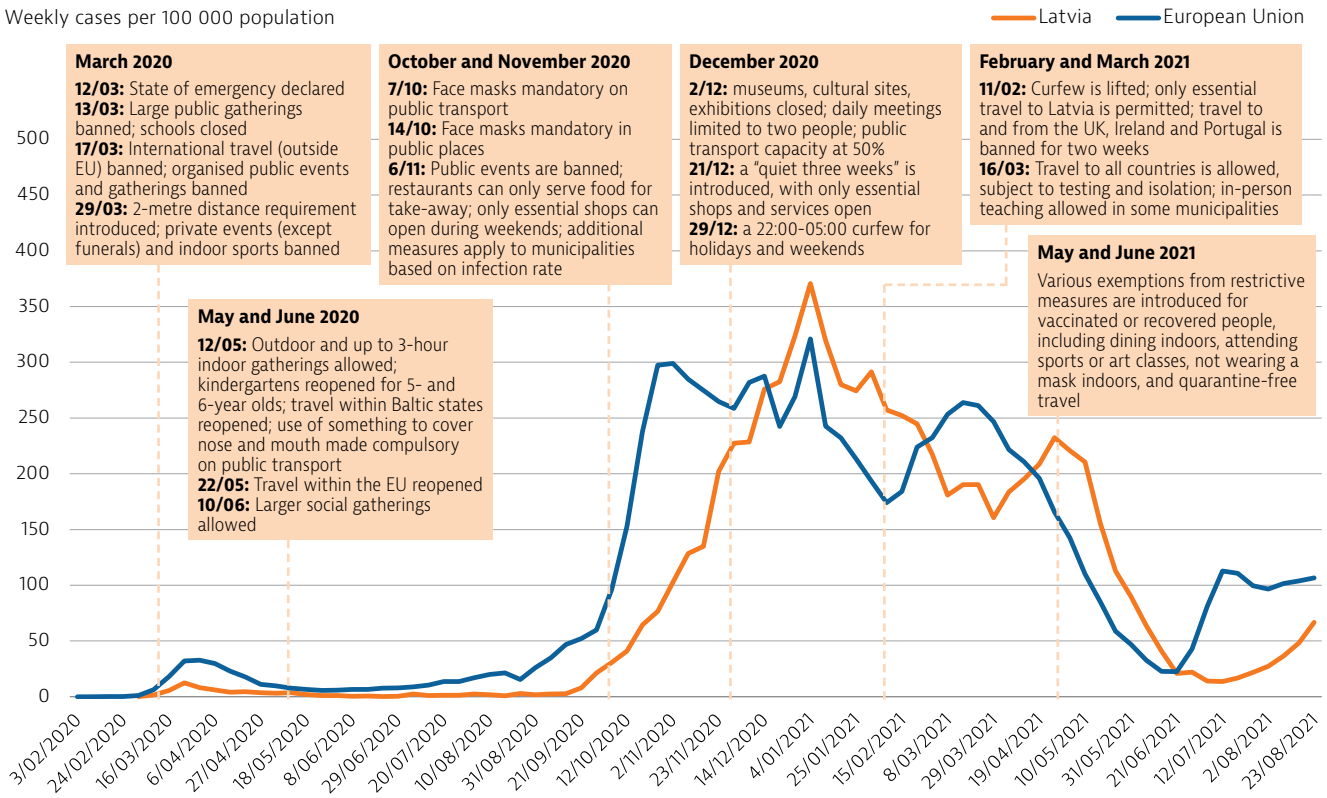
In the summer of 2020, the infection rate was down, and some restrictions were lifted, gradually. However, as cases began to rise steeply in the autumn, restrictions were tightened again, and new measures implemented. In October, proper face masks became mandatory – first on public transport and then in all enclosed public spaces (beforehand, any type of face covering was accepted). In November, all public places were closed, and sporting events were cancelled. Municipalities with high rates of infection saw additional restrictions, such as a ban on visiting other households. In December, a weekend and holiday curfew from 22:00 to 05:00 was instated. After peaking at the beginning of 2021, the infection rate started to decrease, and measures were slowly lifted over the months that followed. As the vaccination rate increased, various exemptions from restrictive measures were introduced for people who were vaccinated or had recovered from COVID-19[5].

The State Disaster Medicine Plan was activated to deal with the COVID-19 pandemic

When the COVID-19 outbreak first hit in early 2020, Latvia activated the State Disaster Medicine Plan, which stated that the Emergency Medical Service was in charge of managing the initial response to the outbreak. Emergency Medical Service teams were deployed to conduct testing of suspected cases and to transport patients to hospital if necessary. The Service was also tasked with monitoring and increasing hospital capacity by reducing unrelated and non-urgent treatments, and distributing personal protective equipment. Contact tracing was introduced and applied to all new cases since the first case in March 2020. Its implementation is considered to have played an important role in controlling the outbreak in the early months.

4. In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).
5. This report covers the COVID-19 situation up until the end of August 2021. It should be noted that after this date, there was a considerable increase in cases, reaching a weekly case rate of nearly 900 per 100 000 population in October 2021. The government has reintroduced measures, including a strict lockdown, a curfew and extended school holidays.

Figure 19. Latvia was hit hard by a second wave of infections at the end of 2020



Note: The EU average is unweighted (the number of countries included in the average varies depending on the week).
Source: ECDC for COVID-19 data and authors for containment measures.

To prepare for the health system impact of COVID-19, capacity was increased and stockpiles created

To increase the capacity of the health workforce, overtime hours were allowed as an exception for medical practitioners working in the Emergency Medical Service and inpatient institutions, and for epidemiologists working in the CDPC. In addition, bonuses were introduced for doctors, health professionals, health workers and pharmacists – worth an additional 20-50 % of monthly salary – for the months of March, April and May. In December 2020, another EUR 32 million was made available for allowances of up to 100 % of monthly salary for doctors dealing with COVID-19 (LSM.LV, 8 December 2020).

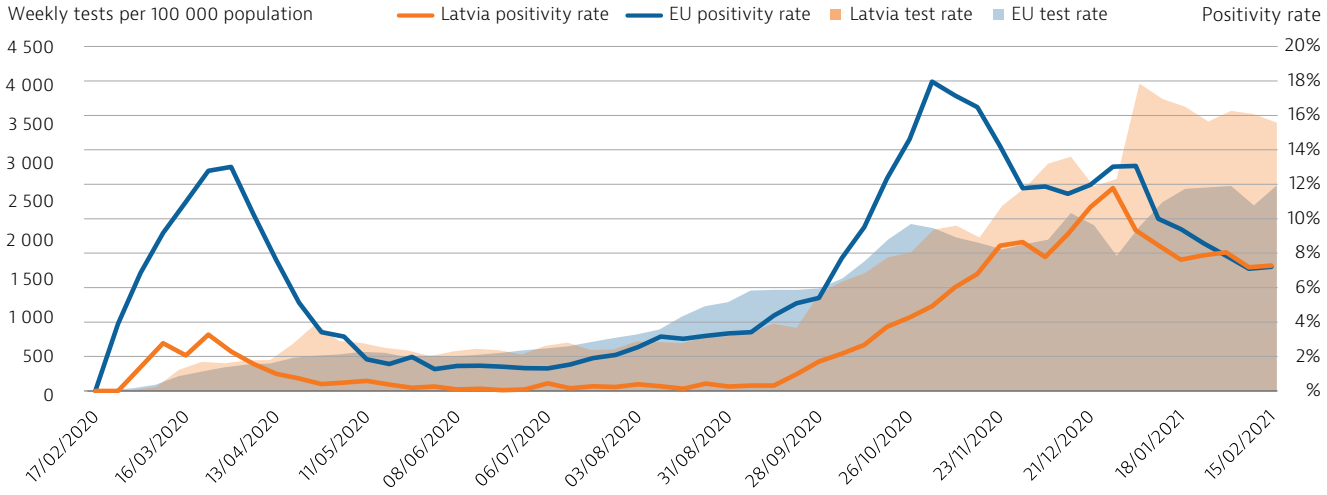
Other steps Latvia took to prepare for the health system impact of COVID-19 included acquiring medical equipment from the private sector, setting up dedicated new structures such as mobile testing points, increasing the capacity of laboratories and stockpiling protective equipment and pharmaceuticals (OECD, 2020).

Despite early preparations, material and staff shortages occurred

Despite these efforts, like many other countries, Latvia struggled with material and staff shortages during the peak of the second wave of the pandemic. When face masks were made mandatory in shops and other public places in October 2020, demand quickly outgrew supply. Rural areas were reported to be particularly affected by this shortage (LSM.LV, 16 October 2020).

Latvia saw a high rate of COVID-19 testing compared to the EU as a whole, while the positivity rate remained relatively low (Figure 20), suggesting that volumes of tests carried out was in line with the dynamics of the epidemic. This was paired with long waiting times at testing facilities: in Riga, people had to wait 5-8 days for a COVID-19 test, while in other areas of the country waiting times were as long as 12 days. These delays were reported to be due mostly to staffing, rather than a shortage of equipment or reagents (LSM.LV, 23 October 2020). In order to manage demand, a doctor's referral was temporarily made mandatory for state-funded testing, and organisation of COVID-19 testing was centralised in October 2020. A central phone number was set up, which people could call to register for a test and be referred to a testing location with availability nearby.

Figure 20. COVID-19 testing rate was above the EU average during Latvia's peak of the pandemic while the positivity rate generally remained low



Note: The EU average is weighted (the number of countries included in the average varies depending on the week)
Source: ECDC.

Demand for hospital and intensive care unit beds peaked in early 2021

As the number of COVID-19 cases increased quickly in autumn 2020, Latvia saw hospital occupation rates rising. In October, the Ministry of Health asked university and regional hospitals to save 15 % of beds for new COVID-19 patients taken in by the Emergency Medical Service (LSM.LV, 30 October 2020). In December, the government allocated EUR 8 million to create additional hospital beds, as 73 % of the 796 beds available for the treatment of COVID-19 patients were occupied (LSM.LV, 8 December 2020). In early January 2021, the number of hospitalised COVID-19 cases peaked at more than 1 200 cases (ECDC, 2021). The weekly number of new admissions to intensive care units also reached a high in the early weeks of 2021. Over the following months, both came down, and by July 2021 hospital occupancy had come down to around 50 cases.

Digital surveillance and tracing were used as part of the Latvian COVID-19 response

In Latvia, the Ministry of Health and CDPC are together responsible for outbreak monitoring and disease surveillance. In January 2020, before even the first confirmed case of COVID-19 in Latvia, information on COVID-19 was made available online for specialists and the public. Data on COVID-19 cases and mortality by municipality were updated daily, and were available from Latvia's Open Data Portal (created with support from the European Regional Development Fund). This open access allowed Latvia's COVID-19 data to be used nationally and internationally (Latvian Open Data Portal, 2020).

Latvia was the first country to launch a COVID-19 contact tracing application, using newly developed exposure notification code that works with both Apple and Google. By February 2021, the Apturi Covid (Stop Covid) app had been downloaded by 16 % of the population. The source code is freely available for other countries or developers to use. Moreover, Latvia's app was connected to those of other countries, using the interoperability solution for mobile tracing and warning apps provided by the European Commission. This meant that Apturi Covid could warn users if they had come into contact with a COVID-19 infected person in Germany, Italy, Ireland or Spain (Baltic Times, 2020).

Both the open sharing of data and codes and the international interoperability of the COVID-19 tracing app highlight the potential power of a European Health Data Space (Box 5).

Health care personnel were prioritised in the COVID-19 vaccination strategy

Vaccinations against COVID-19 started in Latvia on 28 December 2020, with 10 vaccination points within hospitals. Health care professionals treating COVID-19 patients and those working in the Emergency Medical Service were prioritised, followed by all other health care workers, and social care workers and clients. Next in line were people with chronic illnesses and those over the age of 60, as well as emergency services staff, education workers and people in prisons.

In February 2021, a central appointment website and a free hotline were launched. Vaccination sites included state and municipal medical institutions and family doctor practices. Off-site vaccination teams were created, and if necessary, vaccination could be carried out in pharmacies or in large non-medical facilities. By the end of August 2021, 41 % of the Latvian population had received two doses (or equivalent) of a COVID-19 vaccine – below the EU average of 54 % (Figure 21).

Box 5. The European Health Data Space will improve data access and exchange

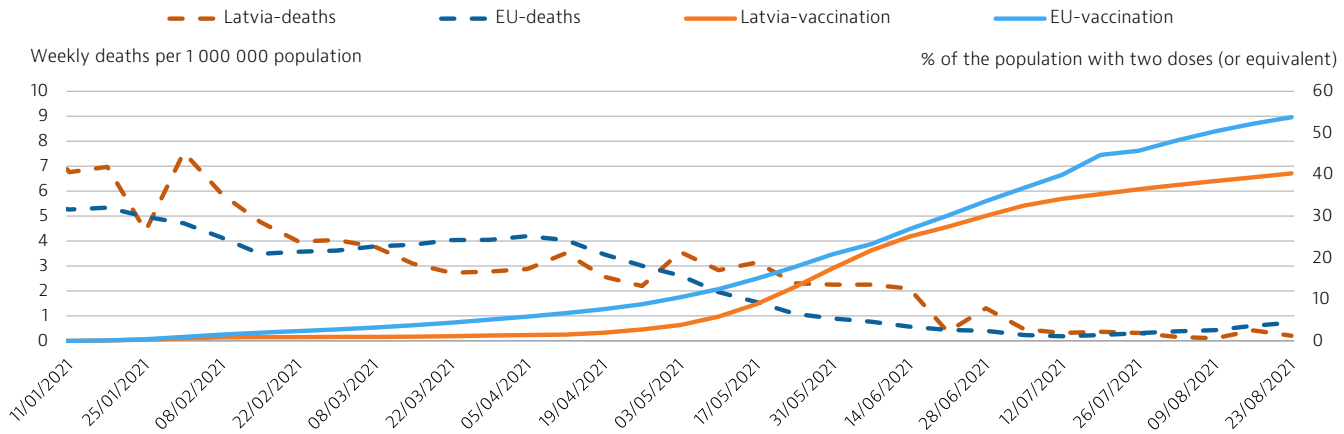
The creation of a European Data Space is one of the priorities of the European Commission over the period 2019-25, including in the health sector. A common European Health Data Space will promote better exchange and access to different types of health data (e.g. electronic health records, genomics data, data from patient registries and so on), to support health care delivery and health research and policy-making.

Source: European Commission (2020).

The entire data system will be built on transparent foundations that fully protect citizens' data and reinforce the portability of their health data. The European Health Data Space will be built on three main pillars:

- a strong system of data governance and rules for data exchange
- data quality
- strong infrastructure and interoperability

Figure 21. Over 40 % of the Latvian population was vaccinated against COVID-19 by the end of August 2021



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and Our World in Data for vaccination rates.

Latvia has taken steps to increase investment in the health sector

Despite increases in recent years, Latvia has among the lowest health care expenditure per capita (see Section 4). To increase funding, the compulsory state social insurance contribution on salaries was increased by one percentage point, half of which is paid by employers and half by employees. The resulting increase in revenue was earmarked for health care, and constituted about EUR 80 million – equivalent to almost 10 % of the state health care budget in 2017. While the additional charge on wages was abolished in 2021, the amount of social security revenues earmarked for health care remained the same (2.78 %). Further, at the end of 2017, the government granted an additional EUR 113.4 million to the health sector for 2018. The priority for the newly available funding was to increase the salaries of health care professionals (Behmane et al., 2019).

Throughout the COVID-19 outbreak, the Latvian government allocated several rounds of additional funding to support the health care system. These included a EUR 254 million strategy (equivalent to more than 20 % of the annual state health care budget) to strengthen laboratory services, improve the infrastructure of health facilities and improve access to health care services, among other objectives (see Box 2). Moreover, the Council of Europe Development Bank approved a EUR 150 million loan to Latvia to help contain the COVID-19 outbreak and ease budgetary pressures on the public health care sector (CEB, 2020).

To help Latvia recover from the impact of the COVID-19 pandemic, the EU is providing funding through its Recovery and Resilience Facility.

Latvia will receive EUR 1.8 billion over the next five years to support a sustainable and inclusive recovery that promotes the green and digital transitions. Around 10 % of this funding is going towards modernising health care, including a EUR 158 million investment in hospitals and health care service providers to strengthen the resilience of the health sector and increase the availability of integrated and high-quality health care services.

6 Key findings

- Over the past two decades, life expectancy in Latvia has increased by 5.5 years, from 70.2 years in 2000 to 75.7 years in 2020. Nevertheless, it remains one of the lowest in the EU, and considerable gender and socioeconomic inequalities exist.

- Latvia has a high prevalence of major behavioural risk factors. It has the highest level of per capita alcohol consumption in the EU, and a higher than average prevalence of smoking and obesity. To improve population health, the government has implemented a number of public health policies, such as a new regulation on alcohol advertising and availability, and a public health strategy. However, limited resources have been devoted to the implementation of these policies.

- In addition to prevention, many deaths in Latvia could be avoided through better health care. In 2018, Latvia had the second highest mortality rate from treatable causes in the EU. Despite improvements in areas such as primary care and cancer screening, there remains considerable scope to invest in improving the quality of the health care system.

- While health expenditure per capita has increased by 75 % since 2010, it remains the fourth lowest in the EU. Only 61 % of health expenditure is publicly funded. The benefits package is relatively limited, and even when services or goods are covered, they are nearly always subject to user co-payment charges. Moreover, publicly funded health services are capped by annual quotas. Once these are met, patients have to either wait until the following year or cover the costs privately.

- As a result, out-of-pocket spending is very high, accounting for 36 % of total health expenditure – more than twice the EU average. This leads to people spending more on health than they can afford (15 % of Latvian households experience catastrophic health spending) and forgoing treatment: the proportion of the Latvian population reporting unmet needs for medical treatment was among the highest in Europe, both before and during the COVID-19 pandemic.

- Despite early implementation of COVID-19 containment strategies, Latvia was hit hard by the second wave of the pandemic at the end of 2020 and the first few months of 2021. While the government had invested in stockpiles and hospital capacity was centrally coordinated, at the peak of the pandemic equipment, staff and bed shortages occurred.

- Latvia's COVID-19 vaccination strategy prioritised frontline health professionals treating COVID-19 patients and working in the Emergency Medical Service, followed by all other health care workers, and social care workers and clients. While the vaccination rate is lower than in the EU on average, by the end of August 2021 41 % of the Latvian population had received two doses (or equivalent).

- During the COVID-19 crisis, Latvia continued to invest in its health care system. In the years before the pandemic, Latvia had been increasing the state health budget. To support the health care system during the pandemic, additional funding was allocated, including EUR 254 million (equivalent to more than 20 % of the annual state health care budget) to strengthen laboratory services, improve the infrastructure of health facilities and improve access to health care services. The health sector will also benefit from the EU Recovery and Resilience fund.

- Digital surveillance and tracing played a role in the Latvian COVID-19 response. The Centre for Disease Prevention and Control started providing COVID-19 information even before the first case was diagnosed. Daily updated statistics are available from Latvia's Open Data Portal. Latvia was the first country to launch a COVID-19 contact tracing application, using newly developed software, and the source code was made available for others to use. Moreover, Latvia's app was connected to those of other countries, using the interoperability solution provided by the European Commission.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Commission

State of Health in the EU
Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

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